

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer and consult the individual plan's evidence of coverage. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefits summary is also available on bluecross.ca.com. However, the plan may simply provide a link to this website and the DMHC's version of this matrix. You may contact the Department of Managed Health Care at (888) HMO-2219 for further assistance regarding the matrix.

Plan Name Blue Cross of California PPO	Plan Contact Phone Number (800) 333-0912
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Coverage summary	
Eligibility requirements	<p>You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria:</p> <ul style="list-style-type: none"> • Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or • Have been enrolled in a post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or • Have been enrolled in a post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage • Plans may decline coverage if you are eligible for parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease. <p>Dependent Coverage-The following dependents may also be enrolled: Subscriber's spouse, Subscriber or spouse's unmarried children; dependent children over age 23 incapable of self-sustaining employment due to certain disabilities. (Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).</p>
The full premium cost if each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers. See Post-MRMIP Graduate Product Rate Chart on this website.
When and under what circumstances benefits cease	<p>Coverage may be terminated by the Plan under the following circumstances:</p> <ul style="list-style-type: none"> • Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. • Termination of Plan type by Plan in which Subscriber or dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) • Non-payment of subscription charges • Fraud or material misrepresentation <p>(This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan).</p>

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The terms under which coverage may be renewed	<p>Coverage under the Plan shall continue, except under the following circumstances:</p> <ul style="list-style-type: none"> • Loss of eligibility by Subscriber or by enrolled Dependents • Non-payment of subscription charges • Fraud or material misrepresentation • Termination of plan type by Plan in which Subscriber or dependents is enrolled (Please contact the Plan's Evidence of Coverage for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) • Subscriber moves out of the service area
Other coverage that may be available if benefits under the described benefit package cease	None
The circumstances under which choice in the selection of physicians and providers is permitted	This is a PPO plan. This plan allows members under all circumstances to chose the physicians and providers for all services. However if they select a non-participating physician or provider they are responsible for a larger co-payment amount and any amounts in excess of network rates. Also the co-payments they pay to non-participating providers do not accumulate toward their yearly maximum copayment limit.

Coverage Summary

Lifetime and annual maximums	\$ 200,000 annual maximum/\$ 750,000 lifetime maximum		
Deductibles	NONE		
Benefit Summary (*)	Co-payments \$ 2,500 per member Yearly Maximum Copayment Limit \$4,000 per family. Once you meet the yearly maximum copayment limit, BC pays 100%. No yearly maximum for Non- Participating Providers.	Limitation	

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Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.	<p>OFFICE VISITS: For Participating Providers \$25 per office visit. For Non-Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable.</p> <p>OTHER SERVICES: 25% of the negotiated rate for other services utilizing Participating Providers. Copayment for Non-Participating Providers is 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.</p>	
Outpatient Services	Outpatient services including but not limited to, surgery and diagnostic procedures.	<p>PROFESSIONAL SERVICES: 25% of negotiated rate for Participating Providers. For Non-Participating Providers 50% of customary and reasonable or billed charges whichever is less and any amount in excess of customary and reasonable.</p> <p>HOSPITAL SERVICES: 25% of the negotiated rate for Participating Providers. Copayment for Non-Participating Providers all charges in excess of a Blue Cross maximum payment of \$380 per day.</p>	Blue Cross limits payment to \$380 per day for Non Participating facilities. (No benefits are provided in a non-contracting hospital in California except in the case of medical emergency).

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Hospitalization Services	Inpatient and Outpatient services including but not limited to, room and board and supplies.	<p>PROFESSIONAL SERVICES: 25% of negotiated rate. For Non Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable.</p> <p>HOSPITAL SERVICES: 25% of negotiated rate for Participating Providers. For Non-Participating Providers all charges in excess of a Blue Cross maximum payment of \$650 per day for Inpatient services or \$380 per day for Outpatient services.</p>	Blue Cross payment is limited to \$650 per day for Inpatient services or \$380 per day for Outpatient services at Non Participating facilities. (No benefits are provided in a non-contracting hospital in California except in the case of medical emergency).
Emergency Health Coverage	Emergency room services at contracted and non contracted facilities for medically necessary emergencies.	HOSPITAL SERVICES: 25% of negotiated fee for Participating Providers. Co-payment for Non-Participating Providers is 25% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable for the first 48 hours. After 48 hours, all charges in excess of \$650 per day**.	
		AMBULATORY SURGICAL CENTERS: 25% of negotiated fee for Participating Providers. Co-payment for Non-Participating Providers is 25% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable.	

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Durable Medical Equipment	Home medical equipment, including but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies.	25% of the negotiated rate for Participating Providers. Copayment for Non-Participating Providers in 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.	Must be certified by a physician and required for care of an illness or injury.
Mental Health Services	Inpatient and outpatient mental health services, including but not limited to, mental health parity services (**2) for serious mental disorders and severe emotional disturbances for children.	INPATIENT: For Participating Providers, 25% of negotiated fee rate. For Non Participating Providers, member pays all charges, except for \$175 per day. OUTPATIENT: For Participating Providers, 25% of negotiated rate. For NonParticipating Providers, the members pays 50% of customary and reasonable charges or billed charges, whichever is less, plus any charges in excess of customary and reasonable.	Inpatient and outpatient services for Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child are not limited as to day and visit maximums. Benefits are provided the same as for other medical conditions. Inpatient services limited to 10 days each calendar year Participating and Non-Participating Providers combined. Member responsible for all costs for visits over 10 days for inpatient services. Out-patient service limited to 15 visits each calendar year Participating and Non-Participating Providers combined. Member responsible for all costs over 15 visits for outpatient services.

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Residential treatment	Transitional residential recovery services.	Not a covered benefit	
Chemical Dependence Services	Substance abuse treatment or rehabilitation		No benefits will be provided for chemical dependency, substance abuse, alcoholism, or drug addiction.
	Inpatient Alcohol and Drug Abuse Detoxification	25% of negotiated fee rate for Participating Providers. For Non Participating Providers. 25% of customary and reasonable or billed charges whichever is less, and any amount in excess of customary and reasonable.	Inpatient Alcohol and Substance Abuse Detoxification is covered on an inpatient basis only, when medically necessary and subject to Blue Cross Prior Authorization. Benefits limited to removal of toxic substances. Outpatient not a covered benefit.
Home Health Service	Home health services through a home health agency Home health and hospice care services (***3)	25% of negotiated fee rate for Participating Provider for Non-participating Providers. 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.	Services require Blue Cross Prior Authorization.
	Home health services through a home health agency		

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Benefit Summary Cont.		Co-payments	Limitation
Custodial care and skilled nursing facilities	Skilled nursing care and skilled nursing facilities services.	Not Covered unless Blue Cross recommends as a medically appropriate more cost effective alternative plan of treatment. For Participating Providers, 25% of Negotiated Fee Rate. For Non-Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable, is the responsibility of the member. Custodial Care is not covered.	

(**1) Percentage co-payments represent a percentage of actual cost. In a PPO, percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges, whichever is less, and enrollees are also responsible for any excess amount.

(**2) Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for further information regarding the conditions subject to mental health parity.

(***3) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.